WEBB COUNTY

LOCAL MILEAGE CLAIM FORM

PERIOD COVERED: FROM _____ TO _____

EMPLOYEE _____   DEPARTMENT _____

SS# _____   ACCOUNT NO. _____

DATE	TIME	DEPARTURE	ODOMETER READING START END	DESTINATION	PURPOSE	MILEAGE

I HEREBY CERTIFY THE ABOVE IS TRUE, CORRECT, AND UNPAID FOR TRAVEL
INCURRED ABSOLUTELY NECESSARY IN THE DISCHARGE OF MY OFFICIAL DUTIES.

APPROVED BY _____

EMPLOYEE SIGNATURE   OFFICIAL / DEPARTMENT HEAD

DATE   DATE

TOTAL MILEAGE _____

@ $. / MILE

TOTAL DUE _____